

OAAS Comprehensive Plan of Care (CPOC) – WORKING DRAFT INSTRUCTIONS

The enclosed Comprehensive Plan Of Care (CPOC) instructions have been developed as a guide to assist you with completion of the OAAS CPOC Working Draft.

The Case Study example for Mr. Melvin Brown presented during the February 2009, Care Planning with SHARe Methodology training workshop is also enclosed. Please take time to review the enclosed CPOC example for Mr. Brown, and then review the instructions below with the goal of becoming familiar with the type of information to be included in each section of the CPOC.

The enclosed CPOC Working Draft copy has not yet been locked. You will need to backspace if you are typing in information to bring table back into alignment. The font size has been set at “9”. You may adjust the font size as needed, as long as page contents are kept intact (e.g., part of page 2 is not on page 3, etc.).

If you are completing a hand written CPOC, be sure to use black or blue ink, and write legibly. You may copy parts of the CPOC that require more space. The same holds true for those who require more space using computer to complete CPOC (e.g., more space needed for Medications, etc.).

If you are using a computer to complete CPOC, place cursor by check boxes, then double click the applicable option. A Form Field Options box will appear – click on the option you need (see Screen Shot on last page of this document).

A Locked and fillable version of both the CPOC and Task list will be provided to you no later than Monday, March 23, 2009.

Questions related to these documents should be forwarded to your OAAS Regional Office.

OAAS Comprehensive Plan of Care (CPOC) – WORKING DRAFT INSTRUCTIONS

PLAN OF CARE (POC)

CPOC SECTION	Guidance on Completion
PROGRAM	<ul style="list-style-type: none"> Check all that apply (e.g., person is applying for EDA, but is also being evaluated for LT-PCS – Check both EDA and LT-PCS)
PLAN TYPE	<ul style="list-style-type: none"> Check option that applies, i.e., if this is the first time this person is being assessed for Home and Community Services (HCBS), you would check “Initial”, if this person is being assessed as part of his/her Annual review, you would check “Annual”. If this person’s functional condition has changed between the time you completed either an Initial, or an Annual assessment, and now requires more or less assistance due to functional decline, or improvement, you will complete a “Status Change” (Revision) assessment and that box would be checked.
SECTION A: IDENTIFYING INFORMATION	<ul style="list-style-type: none"> Self explanatory – check all that apply and complete the sections with the appropriate information. Person’s legal name should be used –(no nick names) Make sure SSN is documented correctly If participant has no Medicaid No. yet, leave blank
SECTION B: PERSONAL REPRESENTATIVE	Check option that applies, and complete as applicable.
SECTION C: LEGAL STATUS	<ul style="list-style-type: none"> Individuals are considered “Competent Major” unless there is a Legal document indicating they are “Interdicted”. Refer to Q & A document for further information related to other Legal term definitions.
SECTION D: POWER OF ATTORNEY	Check all that apply
SECTION E: HOUSEHOLD MEMBERS	<ul style="list-style-type: none"> Include all individuals living in the house, other than participant. If more space is needed, you may copy this page/Section and add other information.
SECTION F: FAMILY NATURAL SUPPORT/ NOT LIVING IN HOUSEHOLD	<ul style="list-style-type: none"> Include all natural (non-paid) support not living in the household. Check all areas that apply.
SECTION G: PHYSICIAN CONTACT INFORMATION	<ul style="list-style-type: none"> List Primary Care physician and all specialists, including dentist, and their contact info. Date Of last visit may be month and year, or just Year, and brief reason for visit (if individual cannot recall reason for visit – note “can’t recall)
SECTION H: DISEASE DIAGNOSES	<ul style="list-style-type: none"> Refer to information you collected on MDS-HC and check all applicable boxes.

OAAS Comprehensive Plan of Care (CPOC) – WORKING DRAFT INSTRUCTIONS

CPOC SECTION	Guidance on Completion
SECTION I: ALLERGIES	<ul style="list-style-type: none"> Check all that applies and provide a brief description of what to look for in the event of an allergic reaction.
SECTION J: MEDICATIONS	<ul style="list-style-type: none"> List all medications listed in Section Q of MDS-HC, plus any other medications that are not listed. Include who is administering medication, as well as other info. as indicated.
SECTION K: MEDICAL PROCEDURES	<ul style="list-style-type: none"> List all Procedures and Treatments listed on MDS-HC, as well as those that are not on MDS-HC, such as C-PAP and Nebulizers". Refer to Medical Procedure definitions in MDS-HC Manual.
SECTION L: SERVICES CURRENTLY UTILIZED	<ul style="list-style-type: none"> Check all services that apply and list the provider's name and frequency of service.
SECTION M: ASSTIVE DEVICES/EQUIPMENT CURRENTLY UTILIZED	<ul style="list-style-type: none"> Refer to MDS-HC for all applicable assistive devices currently utilized, and list any others not specifically listed. Note: CPAP (continuous positive airway pressure) therapy is a common treatment for sleep apnea. CPAP includes a small machine that supplies a constant and steady air pressure, a hose, and a mask or nose piece. A nebulizer is a device used to administer medication to people in the form of a mist inhaled into the lungs.
SECTION N: EMERGENCY EVACUATION INFORMATION	<ul style="list-style-type: none"> Check all that apply. Be sure to specify where emergency equipment is kept in the home if present.
SECTION O: PARTICIPANT PROFILE	<ul style="list-style-type: none"> This section of CPOC "paints a picture" of who this individual is including primary concerns, preferences, etc. Information to complete Subsections 1 through 9 can be gleaned from MDS-HC, and from information gathered during the person centered planning process.
SECTION P: ADLs, IADLs AND OTHER SUPPORTS/SERVICES	<ul style="list-style-type: none"> Codes for ADLs and IADLs are to be gathered from MDS-HC Assessment, Section H. 1 and H. 2. <u>"Needs Assistance"</u> refers to the MDS-HC and assessor needs-based results, not to whether or not a participant/personal representative, family member, etc. has deemed the person needs assistance or not, or whether or not the assistance will be paid or Non-paid support. <u>"Current Support"</u> should describe how this ADL/IADL is currently happening for the participant. For example, does the participant perform this ADL/IADL on his/her own, who assisted him/her during the appropriate look-back period (must be human assistance to count). <u>"Type of Support Required and Preferences"</u> should reflect what the MDS-HC (needs-based assessment) found to be the case, and participant's preferences. Information noted in this section should support assignment of paid support. <u>"Frequency and Duration"</u> column should reflect need for Paid Support, including approximate length of time that will be required for performance of task (this is necessary for completion of budget and Provider Task List for PA purposes, but it should be understood that flexibility is built in as long as units of service are utilized within assigned week. Some task listed in SECTION P of Draft CPOC will not be found on MDS-HC (e.g., Assistance with scheduling of medical appointments, etc.).

OAAS Comprehensive Plan of Care (CPOC) – WORKING DRAFT INSTRUCTIONS

	The assessor will use information gathered during the person centered planning meeting, including participant preferences to determine if paid services are to be included for those items.
CPOC SECTION	Guidance on Completion
SECTION Q: PARTICIPANT/CLIENT ASSESSMENT PROTOCOLS (CAPs)	<ul style="list-style-type: none"> All 32 Client Assessment Protocols (CAPs) from MDS-HC have been listed in this section of Draft CPOC. You are to Check those CAPs that have triggered once you have entered MDS-HC in TeleSys and Triggered the CAPs. You are to Review the triggered CAPs and client's response that triggered that particular CAP, and then determine with the Participant and Personal Rep/family if that CAP needs to be care planned. All CAPs that have a potential for positive impact as a result of services and supports that have been put in place should be addressed (see Mr. Brown's Sample care plan). Refer to Chapter 4 of MDS-HC Manual for further guidance in care planning CAPs.
SECTION R: PLAN OF CARE BUDGET PAGE	<ul style="list-style-type: none"> List Provider Name, Provider #, Procedure Code, # of Units, Cost per Unit, Total Cost, CPOC Start and End Dates n this page. Use Waiver Worksheet to determine values for each of the required fields, or your own system for coming up with accurate values (be sure calculations have been checked for accuracy prior to forwarding to OAAS Regional Office.
SECTION S: PLAN OF CARE (POC) PARTICIPANTS	<ul style="list-style-type: none"> All POC participants should sign indicating they attended CPOC planning meeting. Signature of Support Coordinator/ Assessor should also appear in this section. Support Coordinator/Assessor Supervisor's signature indicates that He/she has thoroughly reviewed the CPOC for accuracy and completeness prior to submitting to OAAS Regional Office. Participant and/or Personal Representative must sign after having reviewed all CPOC information.
PARTICIPANT NAME MEDICAID # DATE DEVELOPED	<ul style="list-style-type: none"> This information must appear in the footer at the bottom of each page of CPOC. Information typed in to the footer will appear on each page once it is typed in one time. To get to the footer, click once in the footer where you are going to type in the name and other information. To get out of the footer, simply click on the body of the document.
OAAS OR DESIGNEE PLAN OF CARE (POC) ACTION	<ul style="list-style-type: none"> This section is reserved for OAAS/DESIGNEE input.

OAAS Comprehensive Plan of Care (CPOC) – WORKING DRAFT INSTRUCTIONS

SCREEN SHOT: Example of pop up when you double click on check boxes in CPOC filed. Click on Checked, Not Checked to indicate correct option.

PLAN OF CARE DRAFT REVISED - 3-13-09 MR BROWN EXAMPLE [Compatibility Mode] - Microsoft Word

Home Insert Page Layout References Mailings Review View Developer Acrobat Design Layout

Print Layout Full Screen Reading Outline Draft Document Views Show/Hide Zoom 100% One Page Two Pages Page Width New Window Arrange All Synchronous Scrolling Split Window Switch Windows Macros

Check Box Form Field Options

Check box size

☒ Auto

☐ Exactly: 100%

Default value

☐ Not checked

☒ Checked

Run macro on

Entry: Exit:

Field settings

Bookmark:

☒ Check box enabled

☐ Calculate on exit

Add Help Text... OK Cancel

Program Choice (Check all that apply):

☐ ADHC Waiver

☒ EDA Waiver

☒ LT-PCS

First Name: Melvin Middle Name: Jose

Birthdate: 5/15/1926 Age:

Gender: ☒ Male ☐ Female

Race:

☐ American Indian/Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐ Asian ☒ White/Caucasian

☐ Black/African American ☐ Hispanic or Latino

Home Phone Number: 225-045-5555

Street Address: 4422 Ford Road

Medicaid No.: 1234578890000

Medicare No.:

Private Insurance Name:

VA Benefits: ☐ Yes, ☒ No

Alternate Phone Number/Cell: 225-034-7777

City: Baton Rouge State: LA Zip Code: 70817

Page: 1 of 25 Words: 8,483

start 4 Novell GroupWise ... CPOC Working Draft ... SHARE Info 4 Microsoft Office ... 12:10 PM